

AMENDED IN SENATE JUNE 29, 2011

AMENDED IN SENATE JUNE 6, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL

No. 399

Introduced by Assembly Member Bonnie Lowenthal

February 14, 2011

An act to amend Sections 14105.192, 14105.45, ~~and 14105.451~~ *14105.451, and 14105.455* of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 399, as amended, Bonnie Lowenthal. Medi-Cal: pharmacy providers: drug reimbursement.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law requires reimbursement to Medi-Cal pharmacy providers for drugs, as prescribed.

This bill would modify the way in which reimbursement to Medi-Cal pharmacy providers is calculated by, in part, authorizing the department to establish a new reimbursement methodology based on average acquisition cost. This bill would make other related changes.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 14105.192 of the Welfare and Institutions
2 Code is amended to read:

3 14105.192. (a) The Legislature finds and declares the
4 following:

5 (1) Costs within the Medi-Cal program continue to grow due
6 to the rising cost of providing health care throughout the state and
7 also due to increases in enrollment, which are more pronounced
8 during difficult economic times.

9 (2) In order to minimize the need for drastically cutting
10 enrollment standards or benefits during times of economic crisis,
11 it is crucial to find areas within the program where reimbursement
12 levels are higher than required under the standard provided in
13 Section 1902(a)(30)(A) of the federal Social Security Act and can
14 be reduced in accordance with federal law.

15 (3) The Medi-Cal program delivers its services and benefits to
16 Medi-Cal beneficiaries through a wide variety of health care
17 providers, some of which deliver care via managed care or other
18 contract models while others do so through fee-for-service
19 arrangements.

20 (4) The setting of rates within the Medi-Cal program is complex
21 and is subject to close supervision by the United States Department
22 of Health and Human Services.

23 (5) As the single state agency for Medicaid in California, the
24 department has unique expertise that can inform decisions that set
25 or adjust reimbursement methodologies and levels consistent with
26 the requirements of federal law.

27 (b) Therefore, it is the intent of the Legislature for the
28 department to analyze and identify where reimbursement levels
29 can be reduced consistent with the standard provided in Section
30 1902(a)(30)(A) of the federal Social Security Act and consistent
31 with federal and state law and policies, including any exemptions
32 contained in the provisions of the act that added this section,
33 provided that the reductions in reimbursement shall not exceed 10
34 percent on an aggregate basis for all providers, services and
35 products.

36 (c) Notwithstanding any other provision of law, the director
37 shall adjust provider payments, as specified in this section.

1 (d) (1) Except as otherwise provided in this section, payments
2 shall be reduced by 10 percent for Medi-Cal fee-for-service benefits
3 for dates of service on and after June 1, 2011.

4 (2) For managed health care plans that contract with the
5 department pursuant to this chapter or Chapter 8 (commencing
6 with Section 14200), except contracts with Senior Care Action
7 Network and AIDS Healthcare Foundation, payments shall be
8 reduced by the actuarial equivalent amount of the payment
9 reductions specified in this section pursuant to contract
10 amendments or change orders effective on July 1, 2011, or
11 thereafter.

12 (3) Payments shall be reduced by 10 percent for non-Medi-Cal
13 programs described in Article 6 (commencing with Section 124025)
14 of Chapter 3 of Part 2 of Division 106 of the Health and Safety
15 Code, and Section 14105.18, for dates of service on and after June
16 1, 2011. This paragraph shall not apply to inpatient hospital
17 services provided in a hospital that is paid under contract pursuant
18 to Article 2.6 (commencing with Section 14081).

19 (4) (A) Notwithstanding any other provision of law, the director
20 may adjust the payments specified in paragraphs (1) and (3) of
21 this subdivision with respect to one or more categories of Medi-Cal
22 providers, or for one or more products or services rendered, or any
23 combination thereof, so long as the resulting reductions to any
24 category of Medi-Cal providers, in the aggregate, total no more
25 than 10 percent.

26 (B) The adjustments authorized in subparagraph (A) shall be
27 implemented only if the director determines that, for each affected
28 product, service or provider category, the payments resulting from
29 the adjustment comply with subdivision (m).

30 (e) Notwithstanding any other provision of this section,
31 payments to hospitals that are not under contract with the State
32 Department of Health Care Services pursuant to Article 2.6
33 (commencing with Section 14081) for inpatient hospital services
34 provided to Medi-Cal beneficiaries and that are subject to Section
35 14166.245 shall be governed by that section.

36 (f) Notwithstanding any other provision of this section, the
37 following shall apply:

38 (1) Payments to providers that are paid pursuant to Article 3.8
39 (commencing with Section 14126) shall be governed by that article.

1 (2) (A) Subject to subparagraph (B), for dates of service on and
2 after June 1, 2011, Medi-Cal reimbursement rates for intermediate
3 care facilities for the developmentally disabled licensed pursuant
4 to subdivision (e), (g), or (h) of Section 1250 of the Health and
5 Safety Code, and facilities providing continuous skilled nursing
6 care to developmentally disabled individuals pursuant to the pilot
7 project established by Section 14132.20, as determined by the
8 applicable methodology for setting reimbursement rates for these
9 facilities, shall not exceed the reimbursement rates that were
10 applicable to providers in the 2008–09 rate year.

11 (B) (i) If Section 14105.07 is added to the Welfare and
12 Institutions Code during the 2011–12 Regular Session of the
13 Legislature, subparagraph (A) shall become inoperative.

14 (ii) If Section 14105.07 is added to the Welfare and Institutions
15 Code during the 2011–12 Regular Session of the Legislature, then
16 for dates of service on and after June 1, 2011, payments to
17 intermediate care facilities for the developmentally disabled
18 licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of
19 the Health and Safety Code, and facilities providing continuous
20 skilled nursing care to developmentally disabled individuals
21 pursuant to the pilot project established by Section 14132.20, shall
22 be governed by the applicable methodology for setting
23 reimbursement rates for these facilities and by Section 14105.07.

24 (g) The department may enter into contracts with a vendor for
25 the purposes of implementing this section on a bid or nonbid basis.
26 In order to achieve maximum cost savings, the Legislature declares
27 that an expedited process for contracts under this subdivision is
28 necessary. Therefore, contracts entered into to implement this
29 section and all contract amendments and change orders shall be
30 exempt from Chapter 2 (commencing with Section 10290) of Part
31 2 Division 2 of the Public Contract Code.

32 (h) To the extent applicable, the services, facilities, and
33 payments listed in this subdivision shall be exempt from the
34 payment reductions specified in subdivision (d) as follows:

35 (1) Acute hospital inpatient services that are paid under contracts
36 pursuant to Article 2.6 (commencing with Section 14081).

37 (2) Federally qualified health center services, including those
38 facilities deemed to have federally qualified health center status
39 pursuant to a waiver pursuant to subsection (a) of Section 1115 of
40 the federal Social Security Act (42 U.S.C. Sec. 1315(a)).

1 (3) Rural health clinic services.

2 (4) Payments to facilities owned or operated by the State
3 Department of Mental Health or the State Department of
4 Developmental Services.

5 (5) Hospice services.

6 (6) Contract services, as designated by the director pursuant to
7 subdivision (k).

8 (7) Payments to providers to the extent that the payments are
9 funded by means of a certified public expenditure or an
10 intergovernmental transfer pursuant to Section 433.51 of Title 42
11 of the Code of Federal Regulations. This paragraph shall apply to
12 payments described in paragraph (3) of subdivision (d) only to the
13 extent that they are also exempt from reduction pursuant to
14 subdivision (l).

15 (8) Services pursuant to local assistance contracts and
16 interagency agreements to the extent the funding is not included
17 in the funds appropriated to the department in the annual Budget
18 Act.

19 (9) Breast and cervical cancer treatment provided pursuant to
20 Section 14007.71 and as described in paragraph (3) of subdivision
21 (a) of Section 14105.18 or Article 1.5 (commencing with Section
22 104160) of Chapter 2 of Part 1 of Division 103 of the Health and
23 Safety Code.

24 (10) The Family Planning, Access, Care, and Treatment (Family
25 PACT) Program pursuant to subdivision (aa) of Section 14132.

26 (i) Subject to the exception for services listed in subdivision
27 (h), the payment reductions required by subdivision (d) shall apply
28 to the benefits rendered by any provider who may be authorized
29 to bill for the service, including, but not limited to, physicians,
30 podiatrists, nurse practitioners, certified nurse-midwives, nurse
31 anesthetists, and organized outpatient clinics.

32 (j) Notwithstanding any other provision of law, for dates of
33 service on and after June 1, 2011, Medi-Cal reimbursement rates
34 applicable to the following classes of providers shall not exceed
35 the reimbursement rates that were applicable to those classes of
36 providers in the 2008–09 rate year, as described in subdivision (f)
37 of Section 14105.191, reduced by 10 percent:

38 (1) Intermediate care facilities, excluding those facilities
39 identified in paragraph (2) of subdivision (f). For purposes of this
40 section, “intermediate care facility” has the same meaning as

1 defined in Section 51118 of Title 22 of the California Code of
2 Regulations.

3 (2) Skilled nursing facilities that are distinct parts of general
4 acute care hospitals. For purposes of this section, “distinct part”
5 has the same meaning as defined in Section 72041 of Title 22 of
6 the California Code of Regulations.

7 (3) Rural swing-bed facilities.

8 (4) Subacute care units that are, or are parts of, distinct parts of
9 general acute care hospitals. For purposes of this subparagraph,
10 “subacute care unit” has the same meaning as defined in Section
11 51215.5 of Title 22 of the California Code of Regulations.

12 (5) Pediatric subacute care units that are, or are parts of, distinct
13 parts of general acute care hospitals. For purposes of this
14 subparagraph, “pediatric subacute care unit” has the same meaning
15 as defined in Section 51215.8 of Title 22 of the California Code
16 of Regulations.

17 (6) Adult day health care centers.

18 (7) Freestanding pediatric subacute care units, as defined in
19 Section 51215.8 of Title 22 of the California Code of Regulations.

20 (k) Notwithstanding Chapter 3.5 (commencing with Section
21 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
22 the department may implement and administer this section by
23 means of provider bulletins; or similar instructions, without taking
24 regulatory action.

25 (l) The reductions described in this section shall apply only to
26 payments for services when the General Fund share of the payment
27 is paid with funds directly appropriated to the department in the
28 annual Budget Act and shall not apply to payments for services
29 paid with funds appropriated to other departments or agencies.

30 (m) Notwithstanding any other provision of this section, the
31 payment reductions and adjustments provided for in subdivision
32 (d) shall be implemented only if the director determines that the
33 payments that result from the application of this section will
34 comply with applicable federal Medicaid requirements and that
35 federal financial participation will be available.

36 (1) In determining whether federal financial participation is
37 available, the director shall determine whether the payments
38 comply with applicable federal Medicaid requirements, including
39 those set forth in Section 1396a(a)(30)(A) of Title 42 of the United
40 States Code.

1 (2) To the extent that the director determines that the payments
2 do not comply with the federal Medicaid requirements or that
3 federal financial participation is not available with respect to any
4 payment that is reduced pursuant to this section, the director retains
5 the discretion to not implement the particular payment reduction
6 or adjustment and may adjust the payment as necessary to comply
7 with federal Medicaid requirements.

8 (n) The department shall seek any necessary federal approvals
9 for the implementation of this section.

10 ~~(o) This section shall not be implemented until federal approval~~
11 ~~is obtained. When federal approval is obtained, the payments~~
12 ~~resulting from the application of subdivision (d) shall be~~
13 ~~implemented retroactively to June 1, 2011, or on such other date~~
14 ~~or dates as may be applicable.~~

15 (o) (1) *The payment reductions and adjustments set forth in*
16 *this section shall not be implemented until federal approval is*
17 *obtained.*

18 (2) *To the extent that federal approval is obtained for one or*
19 *more of the payment reductions and adjustments in this section*
20 *and Section 14105.07, the payment reductions and adjustments*
21 *set forth in Section 14105.191 shall cease to be implemented for*
22 *the same services provided by the same class of providers. In the*
23 *event of a conflict between this section and Section 14105.191,*
24 *other than the provisions setting forth a payment reduction or*
25 *adjustment, this section shall govern.*

26 (3) *When federal approval is obtained, the payments resulting*
27 *from the application of this section shall be implemented*
28 *retroactively to June 1, 2011, or on any other date or dates as may*
29 *be applicable.*

30 (4) *The director may clarify the application of this subdivision*
31 *by means of provider bulletins or similar instructions, pursuant*
32 *to subdivision (k).*

33 (p) Adjustments to pharmacy drug product reimbursement
34 pursuant to this section shall no longer apply when the department
35 determines that the average acquisition cost methodology has been
36 fully implemented pursuant to Section 14105.45.

37 SEC. 2. Section 14105.45 of the Welfare and Institutions Code
38 is amended to read:

39 14105.45. (a) For purposes of this section, the following
40 definitions shall apply:

1 (1) “Average acquisition cost” means the average weighted
 2 cost determined by the department to represent the actual
 3 acquisition cost paid for drugs by Medi-Cal pharmacy providers,
 4 including those that provide specialty drugs. The average
 5 acquisition cost shall not be considered confidential and shall be
 6 subject to disclosure pursuant to the California Public Records
 7 Act (Chapter 3.5 (commencing with Section 6250) of Division 7
 8 of Title 1 of the Government Code).

9 (1)
 10 (2) “Average manufacturers price” means the price reported to
 11 the department by the *federal* Centers for Medicare and Medicaid
 12 Services pursuant to Section 1927 of the Social Security Act (42
 13 U.S.C. Sec. 1396r-8). ~~In the event an average manufacturer’s price~~
 14 ~~is not available, the department shall use the direct price as the~~
 15 ~~average manufacturer’s price.~~

16 (2)
 17 (3) “Average wholesale price” means the price for a drug
 18 product listed as the average wholesale price in the department’s
 19 primary price reference source, *which reflects current prices*
 20 *pursuant to regular updates and maintenance.*

21 ~~(3) “Direct price” means the price for a drug product purchased~~
 22 ~~by a pharmacy directly from a drug manufacturer listed in the~~
 23 ~~department’s primary reference source.~~

24 (4) “Estimated acquisition cost” means the department’s best
 25 estimate of the price generally and currently paid by providers for
 26 a drug product sold by a particular manufacturer or principal labeler
 27 in a standard package.

28 (5) “Federal upper limit” means the maximum per unit
 29 reimbursement when established by the *federal* Centers for
 30 Medicare and Medicaid Services and published by the department
 31 in Medi-Cal pharmacy provider bulletins and manuals.

32 (6) “Generically equivalent drugs” means drug products with
 33 the same active chemical ingredients of the same strength, ~~quantity,~~
 34 and dosage form, and of the same generic drug name, as determined
 35 by the United States Adopted Names (USAN) and accepted by the
 36 federal Food and Drug Administration (FDA), as those drug
 37 products having the same chemical ingredients.

38 (7) “Legend drug” means any drug whose labeling states
 39 “Caution: Federal law prohibits dispensing without prescription,”
 40 “Rx only,” or words of similar import.

1 (8) “Maximum allowable ingredient cost” (MAIC) means the
2 maximum amount the department will reimburse Medi-Cal
3 pharmacy providers for generically equivalent drugs.

4 (9) “Innovator multiple source drug,” “noninnovator multiple
5 source drug,” and “single source drug” have the same meaning as
6 those terms are defined in Section 1396r-8(k)(7) of Title 42 of the
7 United States Code.

8 (10) “Nonlegend drug” means any drug whose labeling does
9 not contain the statement referenced in paragraph (7).

10 ~~(11) “Selling price” means the price used in the establishment~~
11 ~~of the estimated acquisition cost. The department shall base the~~
12 ~~selling price on the average manufacturer’s price plus a percent~~
13 ~~markup determined by the department to be necessary for the~~
14 ~~selling price to represent the average purchase price paid by retail~~
15 ~~pharmacies in California. The selling price shall not be considered~~
16 ~~confidential and shall be subject to disclosure under the California~~
17 ~~Public Records Act (Chapter 3.5 (commencing with Section 6250)~~
18 ~~of Division 7 of Title 1 of the Government Code).~~

19 *(11) “Pharmacy warehouse,” as defined in Section 4163 of the*
20 *Business and Professions Code, means a physical location licensed*
21 *as a wholesaler for prescription drugs that acts as a central*
22 *warehouse and performs intracompany sales or transfers of those*
23 *drugs to a group of pharmacies under common ownership and*
24 *control.*

25 *(12) “Specialty drugs” means drugs that generally require*
26 *special handling, complex dosing regimens, specialized*
27 *self-administration at home by a beneficiary or caregiver, or*
28 *specialized nursing facility services, or may include extended*
29 *patient education, counseling, monitoring, or clinical support.*
30 *Specialty drugs may also include those drugs that the department*
31 *determines are specialty drugs pursuant to subdivision (f) of*
32 *Section 14105.3.*

33 ~~(12)~~

34 (13) “Volume weighted average” means the aggregated average
35 volume for ~~generically equivalent~~ *a group of legend or nonlegend*
36 *drugs, weighted by each drug’s percentage of the group’s total*
37 *volume in the Medi-Cal fee-for-service program during the*
38 *previous six months. For purposes of this paragraph, volume is*
39 *based on the standard billing unit used for the*~~generically~~
40 ~~equivalent~~ *legend or nonlegend drugs.*

1 (14) “Wholesaler” means a drug wholesaler that is engaged in
2 wholesale distribution of prescription drugs to retail pharmacies
3 in California.

4 ~~(13)~~

5 (15) “Wholesaler acquisition cost” means the price for a drug
6 product listed as the wholesaler acquisition cost in the department’s
7 primary price reference source, *which reflects current prices*
8 *pursuant to regular updates and maintenance.*

9 ~~(b) (1) Reimbursement to Medi-Cal pharmacy providers for~~
10 ~~legend and nonlegend drugs shall consist of the estimated~~
11 ~~acquisition cost of the drug plus a professional fee for dispensing.~~
12 ~~The~~

13 (b) (1) *Reimbursement to Medi-Cal pharmacy providers for*
14 *legend and nonlegend drugs shall be determined based on one of*
15 *the following:*

16 (A) *The estimated acquisition cost of the drug plus a professional*
17 *fee for dispensing.*

18 (B) *The pharmacy’s usual and customary charge, which means*
19 *the lowest price routinely offered to any segment of the general*
20 *public, plus a professional fee for dispensing.*

21 (C) *The average acquisition cost plus a professional fee for*
22 *dispensing.*

23 (2) *The professional fee shall be seven dollars and twenty-five*
24 *cents (\$7.25) per dispensed prescription until the department*
25 *implements the average acquisition cost methodology, at which*
26 *time the department shall pay retail pharmacy providers the*
27 *professional fee determined pursuant to subparagraph (F) of*
28 *paragraph (5).* The professional fee for legend drugs dispensed to
29 a beneficiary residing in a skilled nursing facility or intermediate
30 care facility shall be eight dollars (\$8) per dispensed prescription.
31 For purposes of this paragraph “skilled nursing facility” and
32 “intermediate care facility” shall have the same meaning as defined
33 in Division 5 (commencing with Section 70001) of Title 22 of the
34 California Code of Regulations.

35 ~~(2)~~

36 (3) The department shall establish the estimated acquisition cost
37 of legend and nonlegend drugs as follows:

38 (A) For single source and innovator multiple source drugs, the
39 estimated acquisition cost shall be equal to the lowest of the

1 average wholesale price minus 17 percent, ~~the selling price, the~~
2 *average acquisition cost*, the federal upper limit, or the MAIC.

3 (B) For noninnovator multiple source drugs, the estimated
4 acquisition cost shall be equal to the lowest of the average
5 wholesale price minus 17 percent, ~~the selling price, the average~~
6 *acquisition cost*, the federal upper limit, or the MAIC.

7 (C) *Average wholesale price shall not be used to establish the*
8 *estimated acquisition cost once the department has determined*
9 *that the average acquisition cost methodology has been fully*
10 *implemented.*

11 ~~(3)~~

12 (4) For purposes of paragraph ~~(2)~~ (3), the department shall
13 establish a list of MAICs for generically equivalent drugs, which
14 shall be published in pharmacy provider bulletins and manuals.
15 The department shall establish a MAIC only when three or more
16 generically equivalent drugs are available for purchase and
17 dispensing by retail pharmacies in California. The department shall
18 update the list of MAICs and establish additional MAICs in
19 accordance with all of the following:

20 (A) The department shall base the MAIC on the mean of the
21 average manufacturer's price of drugs generically equivalent to
22 the particular innovator drug plus a percent markup determined
23 by the department to be necessary for the MAIC to represent the
24 average purchase price paid by retail pharmacies in California.

25 (B) If average manufacturer prices are unavailable, the
26 department shall establish the MAIC in ~~either~~ *one* of the following
27 ways:

28 (i) Based on the volume weighted average of wholesaler
29 acquisition costs of drugs generically equivalent to the particular
30 innovator drug plus a percent markup determined by the department
31 to be necessary for the MAIC to represent the average purchase
32 price paid by retail pharmacies in California.

33 (ii) Pursuant to a contract with a vendor for the purpose of
34 surveying drug price information, collecting data, and calculating
35 a proposed MAIC.

36 (iii) *Based on the volume weighted average acquisition cost of*
37 *drugs generically equivalent to the particular innovator drug*
38 *adjusted by the department to represent the average purchase*
39 *price paid by Medi-Cal pharmacy providers.*

1 ~~(C)~~ The department may enter into contracts with a vendor for
 2 the purpose of this section on a bid or nonbid basis. In order to
 3 achieve maximum cost savings, the Legislature declares that an
 4 expedited process for contracts under this section is necessary.
 5 Therefore, contracts entered into on a nonbid basis shall be exempt
 6 from Chapter 2 (commencing with Section 10290) of Part 2 of
 7 Division 2 of the Public Contract Code.

8 ~~(D)~~
 9 (C) The department shall update MAICs at least every three
 10 months and notify Medi-Cal providers at least 30 days prior to the
 11 effective date of a MAIC.

12 ~~(E)~~
 13 (D) The department shall establish a process for providers to
 14 seek a change to a specific MAIC when the providers believe the
 15 MAIC does not reflect current available market prices. If the
 16 department determines a MAIC change is warranted, the
 17 department may update a specific MAIC prior to notifying
 18 providers.

19 ~~(F)~~
 20 (E) In determining the average purchase price, the department
 21 shall consider the provider-related costs of the products that
 22 include, but are not limited to, shipping, handling, storage, and
 23 delivery. Costs of the provider that are included in the costs of the
 24 dispensing shall not be used to determine the average purchase
 25 price.

26 (5) (A) *The department may establish the average acquisition*
 27 *cost in one of the following ways:*

28 (i) *Based on the volume weighted average acquisition cost*
 29 *adjusted by the department to ensure that the average acquisition*
 30 *cost represents the average purchase price paid by retail*
 31 *pharmacies in California.*

32 (ii) *Based on the proposed average acquisition cost as*
 33 *calculated by the vendor pursuant to subparagraph (B).*

34 (iii) *Based on a national pricing benchmark obtained from the*
 35 *federal Centers for Medicare and Medicaid Services or on a similar*
 36 *benchmark listed in the department's primary price reference*
 37 *source adjusted by the department to ensure that the average*
 38 *acquisition cost represents the average purchase price paid by*
 39 *retail pharmacies in California.*

1 (B) For the purposes of paragraph (3), the department may
2 contract with a vendor for the purposes of surveying drug price
3 information, collecting data from providers, wholesalers, or drug
4 manufacturers, and calculating a proposed average acquisition
5 cost.

6 (C) (i) Medi-Cal pharmacy providers shall submit drug price
7 information to the department or a vendor designated by the
8 department for the purposes of establishing the average acquisition
9 cost. The information submitted by pharmacy providers shall
10 include invoice prices known to the provider on the date of delivery
11 as the acquisition cost of the drug products purchased. Pharmacy
12 warehouses shall be exempt from the survey process. Pharmacy
13 invoice information shall be considered confidential and shall not
14 be subject to public disclosure under the California Public Records
15 Act (Chapter 3.5 (commencing with Section 6250) of Division 7
16 of Title 1 of the Government Code).

17 (ii) Pharmacy providers that fail to submit drug price
18 information to the department or the vendor as required by this
19 subparagraph shall receive timely notice that if they do not provide
20 the required information within 15 business days, they may be
21 subject to suspension under subdivisions (a) and (c) of Section
22 14123.

23 (D) (i) For new drugs or new formulations of existing drugs,
24 where drug price information is unavailable pursuant to clause
25 (i) of subparagraph (C), drug manufacturers and wholesalers shall
26 submit drug price information to the department or a vendor
27 designated by the department for the purposes of establishing the
28 average acquisition cost. Drug price information shall include,
29 but not be limited to, net unit sales of a drug product sold to retail
30 pharmacies in California divided by the total number of units of
31 the drug sold by the manufacturer or wholesaler in a specified
32 period of time determined by the department.

33 (ii) Drug products from manufacturers and wholesalers that
34 fail to submit drug price information to the department or the
35 vendor as required by this subparagraph may not be a
36 reimbursable benefit of the Medi-Cal program for those
37 manufacturers and wholesalers until the department has
38 established the average acquisition cost for those drug products.

39 (E) Drug pricing information provided to the department or a
40 vendor designated by the department for the purposes of

1 *establishing the average acquisition cost pursuant to this section*
2 *shall be confidential and shall be exempt from disclosure under*
3 *the California Public Records Act (Chapter 3.5 (commencing with*
4 *Section 6250) of Division 7 of Title 1 of the Government Code).*

5 *(F) Prior to the implementation of an average acquisition cost*
6 *methodology, the department shall collect data through a survey*
7 *of pharmacy providers for purposes of establishing a professional*
8 *fee for dispensing in compliance with federal Medicaid*
9 *requirements, and shall collect data through a survey of pharmacy*
10 *providers, including specific data from pharmacy providers that*
11 *dispense specialty drugs, for purposes of establishing a*
12 *professional fee for dispensing specialty drugs in compliance with*
13 *federal Medicaid requirements.*

14 *(i) The department shall seek stakeholder input on the retail*
15 *pharmacy factors and elements used for the pharmacy survey*
16 *relative to both average acquisition costs and dispensing costs.*

17 *(ii) For specialty drug products provided by pharmacy*
18 *providers, a differential professional fee or payment for services*
19 *to provide specialized care shall be provided and may be*
20 *considered as part of the contracts established pursuant to*
21 *subdivision (f) of Section 14105.3.*

22 *(G) When the department implements the average acquisition*
23 *cost methodology, the department shall update the Medi-Cal claims*
24 *processing system to reflect the average acquisition cost of drugs*
25 *not later than 30 days after the department has established average*
26 *acquisition cost pursuant to subparagraph (A).*

27 *(H) Notwithstanding any other provision of law, if the*
28 *department implements average acquisition cost pursuant to clause*
29 *(i) or (ii) of subparagraph (A), the department shall update actual*
30 *acquisition costs at least every three months based on average*
31 *acquisition cost survey invoices collected in that three-month*
32 *period and shall notify Medi-Cal providers at least 30 days prior*
33 *to the effective date of any change in an actual acquisition cost.*

34 *(I) The department shall establish a process for providers to*
35 *seek a change to a specific average acquisition cost when the*
36 *providers believe the average acquisition cost does not reflect*
37 *current available market prices and shall update the average*
38 *acquisition cost within one week of receipt of reasonable*
39 *information showing that the average acquisition cost does not*
40 *reflect current available market prices.*

1 ~~(e) The department shall update the Medi-Cal claims processing~~
2 ~~system to reflect the selling price of drugs not later than 30 days~~
3 ~~after receiving the average manufacturer's price.~~

4 ~~(d) In order to maintain beneficiary access to prescription drug~~
5 ~~services, no later than 30 days after the department initially~~
6 ~~implements selling price as a component of estimated acquisition~~
7 ~~cost, pursuant to paragraph (2) of subdivision (b), the department~~
8 ~~shall make a one-time adjustment to the dispensing fees paid to~~
9 ~~pharmacy providers in accordance with paragraph (1) of~~
10 ~~subdivision (b). This change shall only be made if selling price~~
11 ~~results in a lower aggregate drug reimbursement. Any increase in~~
12 ~~dispensing fee made pursuant to this subdivision shall not exceed~~
13 ~~the aggregate savings associated with the implementation of selling~~
14 ~~price. At least 30-days prior to implementing the dispensing fee~~
15 ~~increase, the department shall issue a copy of the department's~~
16 ~~request for federal approval pursuant to subdivision (e), to the~~
17 ~~chairperson in each house that considers appropriations and the~~
18 ~~Chairperson of the Joint Legislative Budget Committee, or~~
19 ~~whatever lesser time the Chairperson of the Joint Legislative~~
20 ~~Budget Committee or his or her designee may determine.~~

21 ~~(e)~~

22 ~~(c) The director shall implement this section in a manner that~~
23 ~~is consistent with federal Medicaid law and regulations. The~~
24 ~~director shall seek any necessary federal approvals for the~~
25 ~~implementation of this section. This section shall be implemented~~
26 ~~only to the extent that federal approval is obtained.~~

27 ~~(f)~~

28 ~~(d) Notwithstanding Chapter 3.5 (commencing with Section~~
29 ~~11340) of Part 1 of Division 3 of Title 2 of the Government Code,~~
30 ~~the department may take the actions specified in *implement* this~~
31 ~~section by means of a provider bulletin or notice, policy letter, or~~
32 ~~other similar instructions, without taking regulatory action.~~

33 ~~(g) The department shall issue a Medi-Cal pharmacy~~
34 ~~reimbursement fact sheet to the chairperson of the committee in~~
35 ~~each house of the Legislature that considers appropriations no later~~
36 ~~than March 1, 2008. The reimbursement fact sheet shall contain,~~
37 ~~but not be limited to, available data and information regarding the~~
38 ~~change in reimbursement due to the federal Deficit Reduction Act~~
39 ~~of 2005 implementation of average manufacturer's price based~~
40 ~~federal upper limits, the implementation of selling price, change~~

1 in the average wholesale price reported to the department by the
2 primary price reference source, change in pharmacy dispensing
3 fees, prescription drug volume trends, and the number of active
4 Medi-Cal pharmacy providers. The fact sheet shall also contain
5 general information and definitions regarding drug pricing
6 terminology and a description of pharmacy claims processing in
7 Medi-Cal.

8 (e) The department may enter into contracts with a vendor for
9 the purposes of implementing this section on a bid or nonbid basis.
10 In order to achieve maximum cost savings, the Legislature declares
11 that an expedited process for contracts under this section is
12 necessary. Therefore, contracts entered into to implement this
13 section, and all contract amendments and change orders, shall be
14 exempt from Chapter 2 (commencing with Section 10290) of Part
15 2 of Division 2 of the Public Contract Code.

16 (f) (1) The rates provided for in this section shall be
17 implemented only if the director determines that the rates will
18 comply with applicable federal Medicaid requirements and that
19 federal financial participation will be available.

20 (2) In determining whether federal financial participation is
21 available, the director shall determine whether the rates comply
22 with applicable federal Medicaid requirements, including those
23 set forth in Section 1396a(a)(30)(A) of Title 42 of the United States
24 Code.

25 (3) To the extent that the director determines that the rates do
26 not comply with applicable federal Medicaid requirements or that
27 federal financial participation is not available with respect to any
28 rate of reimbursement described in this section, the director retains
29 the discretion not to implement that rate and may revise the rate
30 as necessary to comply with federal Medicaid requirements.

31 (g) The director shall seek any necessary federal approvals for
32 the implementation of this section.

33 (h) Adjustments to pharmacy drug product payment pursuant
34 to Section 14105.192 shall no longer apply when the department
35 determines that the average acquisition cost methodology has been
36 fully implemented.

37 (i) Prior to implementation of this section, the department shall
38 provide the appropriate fiscal and policy committees of the
39 Legislature with information on the department's plan for

1 *implementation of the average acquisition cost methodology*
2 *pursuant to this section.*

3 *SEC. 3. Section 14105.451 of the Welfare and Institutions Code*
4 *is amended to read:*

5 14105.451. (a) (1) The Legislature finds and declares all of
6 the following:

7 (A) The United States Department of Health and Human
8 Services has identified the critical need for state Medicaid agencies
9 to establish pharmacy reimbursement rates based on a pricing
10 benchmark that reflects actual acquisition costs.

11 (B) The Medi-Cal program currently uses a methodology based
12 on average wholesale price (AWP).

13 (C) Investigations by the federal Office of Inspector General
14 have found that average wholesale price is inflated relative to
15 average acquisition cost.

16 (2) Therefore, it is the intent of the Legislature to enact
17 legislation by August 1, 2011, that provides for development of a
18 new reimbursement methodology that will enable the department
19 to achieve savings while continuing to reimburse pharmacy
20 providers in compliance with federal law.

21 (b) The department may *only* require providers, manufacturers,
22 and wholesalers to submit ~~any data the director determines~~
23 ~~necessary or useful~~ *information that is permitted pursuant to*
24 *Section 14105.45* in preparing for the transition from a
25 methodology based on average wholesale price to a methodology
26 based on actual acquisition cost.

27 (c) *If the AWP ceases to be updated and current by the*
28 *department's primary price reference source vendor, the*
29 *department may direct the fiscal intermediary to establish a process*
30 *with the primary price reference source vendor to temporarily*
31 *report the AWP consistent with the definition of AWP in Section*
32 *14105.45. If this process is established, it shall be limited in scope*
33 *and duration, and shall cease when the department has fully*
34 *implemented the average acquisition cost methodology pursuant*
35 *to Section 14105.45.*

36 *SEC. 4. Section 14105.455 of the Welfare and Institutions Code*
37 *is amended to read:*

38 14105.455. (a) Pharmacy providers shall submit their usual
39 and customary charge when billing the Medi-Cal program for
40 prescribed drugs.

1 ~~(b) “Usual and customary charge” means the lower of the~~
2 ~~following:~~

3 ~~(1) The lowest price reimbursed to the pharmacy by other~~
4 ~~third-party payers in California, excluding Medi-Cal managed care~~
5 ~~plans and Medicare Part D prescription drug plans.~~

6 ~~(2) The lowest price routinely offered to any segment of the~~
7 ~~general public.~~

8 ~~(e) Donations or discounts provided to a charitable organization~~
9 ~~are not considered usual and customary charges.~~

10 *(b) “Usual and customary charge” means the lowest price*
11 *routinely offered to any segment of the general public.*

12 ~~(d)~~

13 *(c) Pharmacy providers shall keep and maintain records of their*
14 *usual and customary charges for a period of three years from the*
15 *date the service was rendered.*

16 ~~(e)~~

17 *(d) Payment to pharmacy providers shall be the lower of the*
18 *pharmacy’s usual and customary charge or the reimbursement rate*
19 *pursuant to subdivision (b) of Section 14105.45.*

20 ~~(f)~~

21 *(e) Notwithstanding Chapter 3.5 (commencing with Section*
22 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*
23 *the department may take the actions specified in *implement* this*
24 *section by means of a provider bulletin or notice, policy letter, or*
25 *other similar instructions, without taking regulatory action.*

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**All matter omitted in this version of the bill
appears in the bill as amended in the
Senate, June 6, 2011. (JR11)**